MILITARY LEAVE

NOTICE/ELECTION OF HEALTH CARE COVERAGE CONTINUATION

Date of Notice: _____

Dear _____ (Qualified Beneficiary/ies):

This letter contains information regarding your right to continue your group health plan coverage under the Commonwealth of Virginia Health Benefits Program while on active military duty.

The Public Health Service Act requires that group health plans sponsored by government employers offer employees, their spouses and dependent children the opportunity for continuation of health coverage (called Extended Coverage) at group rates (102% of premium) in certain instances where coverage would otherwise terminate. These instances which ordinarily result in a loss of coverage are called qualifying events. An employee going on military leave is considered a qualifying event.

Due to the extraordinary circumstances the nation finds itself in, the Commonwealth of Virginia has revised this policy on Extended Coverage so that employees who are called to active military duty and their families, may continue their coverage for up to 18 months by paying the same contribution that active employees pay.

The health plan coverage provided to you and your enrolled family members by the Commonwealth of Virginia will be terminated as of (**date coverage will end**), due to you beginning leave without pay as a result of being called to active duty which occurred on (**date of qualifying event**). You and your family members are entitled to continue the same health coverage you elected under the State Health Benefits Program for the period beginning on (**date Extended Coverage begins**) and ending on (**date Extended Coverage ends 18 months from the begin date**). If you do not elect Extended Coverage by (**date election period ends**), your coverage will be terminated.

In order to maintain continuation coverage under the plan, each person must meet the following conditions:

1. You must elect continuation coverage within 60 days of the date on which coverage is lost due to the event or 60 days from the date of this notice, whichever is later.
2. You must make timely payments as described on page five of this document.
3. You must not become covered by any other group health plan except for coverage provided by the military

If you have questions regarding this election notice, please contact (**Name of Benefits Administrator**) by calling (**telephone number**) or writing to (**address**). Direct questions regarding group health plan provisions to your insurance carrier.

Your Rights. If you are an ***employee*** covered under the State Health Benefits Program, you have the right to choose Extended Coverage for yourself and covered family members at the regular employee contribution rate.

If you do not choose continuation coverage, your group health insurance coverage will terminate the end of the month following the date your leave without pay begins. If you choose Extended Coverage within the required time limits, the State Health Benefits Program is required to give you coverage which is identical to the coverage provided to similarly situated active employees and their families. **As an employee who has been activate to military duty you and your covered dependent will be charged the regular state contribution charged to active employees.**

Additional Responsibilities: You or your covered dependents may have what is considered a second qualifying event. If you are the spouse or dependent child you are entitled to elect 18 months of Extended Coverage as a result of an employee being activated to military duty. You could extend coverage to a total of 36 months from the original event date if, during the initial 18 month period, one of the following occurs: the divorce or legal separation of the former employee from the former employee's spouse, or the former employee's death or entitlement to Medicare. In addition if you are the dependent child of the former employee and you lose status as a dependent, you could extend coverage to a total of 36 months from the original qualifying event date. If you experience one of these events, please contact your Benefits Administrator. Under the law, you and your family member(s) have the responsibility to inform the State Health Benefits Program Benefits Administrator of a divorce or child losing dependent status under the State Health Benefits Program within 60 days of the date of the event.

When the Benefits Administrator is notified that a second event has happened, they will, in turn, notify you of your Extended Coverage rights. Essentially dependents of an employee who experience a second qualifying event may receive an additional 18 months of coverage for a total of 36 months by paying 102 percent of the plan's actual premium cost.

Disability Extension: Under current law, if an individual is entitled to Extended Coverage because of going on military leave, the plan is generally required to make Extended Coverage available to that individual for 18 months. However, if the individual entitled to Extended Coverage is disabled (as determined under the Social Security Act) and satisfies the applicable notice requirements, the plan must provide Extended Coverage for 29 months rather than 18 months. This disability extension will apply if the individual is disabled at the time of the qualifying event or if the individual becomes disabled at any time during the first 60 days of Extended Coverage. Non-disabled family members are also entitled to the 29-month disability extension. The cost of coverage during the 11-month extension is 150% of the applicable premium.

The affected individual must notify the Benefits Administrator within 30 days of any final determination that the individual is no longer disabled. In no event will continuation

coverage last beyond three years from the date of the event that originally made a qualifying beneficiary eligible to elect coverage.

Definition of Qualified Beneficiary: Individuals entitled to Extended Coverage are called qualified beneficiaries. Individuals who may be qualified beneficiaries are the spouse, the dependent children of a covered employee and, in certain circumstances, the covered employee. Under current law, in order to be a qualified beneficiary, an individual must generally be covered under a group health plan on the day before the event that causes a loss of coverage (in this case beginning leave without pay as a result of beginning military leave). Additionally, a child born to the covered employee, or who is placed for adoption with the covered employee, during the period of Extended Coverage is also a qualified beneficiary.

Termination of Coverage: Extended Coverage may be terminated for the following reasons:

1. The maximum period of coverage has been reached;
2. You fail to make timely payments;
3. You become covered by other insurance that does not have a pre-existing limitation that applies to you; this does not include coverage offered by the military.
4. You or your dependents become entitled to Medicare;
5. The Commonwealth of Virginia ceases to provide group health plan coverage to any employee;
6. A disabled qualified beneficiary ceases to be disabled according the Social Security Administration after an 11-month extension has begun.

After your Extended Coverage period has ended, you will be eligible for conversion of your group health plan coverage to an individual policy without evidence of insurability, subject to the same conversion privilege that applies under your group health plan. You will be informed of your conversion rights before your Extended Coverage period ends.

Duration of Extended Coverage: Under the Extended Coverage rules, there are situations in which a group health plan may stop making Extended Coverage available earlier than usually permitted. One of those situations is where the qualified beneficiary obtains coverage under another group health plan. **(Coverage provided by the military does not prevent enrollment in Extended Coverage.)** Furthermore, if the other group health plan limits or excludes coverage for any preexisting condition of the qualified beneficiary, the plan providing the Extended Coverage cannot stop making the coverage available merely because of the coverage under the other group health plan. You do not have to show that you are insurable to choose Extended Coverage. However, you will have to pay all or part of the premium for your continuation coverage. There is a grace period of at least 30 days for payment of the regularly scheduled premium.

Plans, Rates and Enrollment Form(s). Extended Coverage monthly premium rates are attached for your reference. Each qualified beneficiary has an independent right to elect Extended Coverage. The initial offer for Extended Coverage must be for benefits identical to those in effect prior to the qualifying event. Unless the covered dependents of the employee move out of state, in which case they may elect coverage under a different plan. An election form and enrollment/waiver form are attached for the purposes of enrollment and must be submitted within the time limitations previously described.

Additional forms may be obtained from your Benefits Administrator or from the Department of Human Resource Management Web site at www.dhrm.state.va.us/hbenefit.htm.

Medical Reimbursement Accounts. Employees who are enrolled in a Medical Reimbursement Account may also choose to extend their current participation in that program. Contributions may be made on a pre-tax basis in a lump sum out of the final paycheck or on an after-tax basis in the form of a monthly check to Fringe Benefits Management Company (address available through your Benefits Administrator).

HIPAA Certificate of Coverage: A Certificate of Coverage is included with this Election Notice due to the termination of coverage event.

Election: All qualified beneficiaries have the right to continue any of the plans (health and/or Medical Reimbursement Account) in which they were enrolled on the day before the qualifying event. Your health insurance will be canceled on (**date coverage ends**). It will be reinstated retroactively upon your timely election of Extended Coverage. Please indicate either your election or declination of Extended Coverage by submitting the attached Election Form. In addition, you must complete the enclosed enrollment/waiver form.

Send your completed election form and enrollment/waiver form to: (**Benefits Administrator's name and address)**

Premium Payments: Your first premium payment is due to the carrier no later than 45 days after the date of your Extended Coverage election (or the date indicated on your billing statement, if applicable) and should include the period of coverage from the date of your qualifying event to the date of your Extended Coverage election and any regularly scheduled monthly premium that becomes due between your election and the end of the 45-day period (or the amount indicated on your billing statement, if applicable). After the first payment, monthly premium payments are due on the first day of the coverage period, but no later than 30 days after the due date (or the date indicated on your billing statement, if applicable).

Attachments: Military Leave Extended Coverage Monthly Costs
Enrollment/Waiver Form
Certificate(s) of Creditable Health Coverage

Extended Coverage Election/Declination Form

Please indicate applicable elections or declinations of Extended Coverage below:

Employee Name: _____ SSN: _____

I wish to elect Extended Coverage
I wish to decline Extended Coverage
Does not apply

Signature: _____ Date: _____

Spouse's Name: _____ SSN: _____

I wish to elect Extended Coverage
I wish to decline Extended Coverage
Does not apply

Signature: _____ Date: _____

Dependent's Name: _____ SSN: _____
(If more than one dependent, list on separate sheet—parent may sign for dependents under age 18)

I wish to elect Extended Coverage
I wish to decline Extended Coverage
Does not apply

Signature: _____ Date: _____

Please indicate your election of Medical Reimbursement Account Extended Coverage below:

I wish to elect Extended Coverage
I wish to decline Extended Coverage
Does not apply

Signature: _____ Date: _____

This form should be returned within the required time frame to your Benefits Administrator. If Extended Coverage is elected, an Enrollment/Waiver Form must accompany this form. Your right to Extended Coverage (related to the event noted) will be lost if you do not elect coverage within 60 days of the date on which coverage ends due to the qualifying event or 60 days from the date of this notice, whichever is later.

Commonwealth of Virginia
Certificate of Creditable Health Coverage

This certificate provides evidence of your prior creditable health coverage. You may need to furnish this certificate if you become eligible under a health plan that excludes coverage for certain medical conditions that you have before you enroll. This certificate, as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), is furnished to everyone leaving the State Health Benefits Program or the State Retiree Health Benefits Program (except for Medicare Supplement Plans). If you become covered under another health plan, check with the plan administrator to see if you need to provide this certificate. It would apply if your new plan has a pre-existing conditions provision and medical advice, diagnosis, care or treatment for such a medical condition was received or recommended for you or a covered family member within the six-month period before enrollment in the new plan. If you have at least 18 months of creditable service as defined by HIPAA, you may have certain additional rights which may be exercised when securing individual coverage. Please be advised that insurers that offer individual health plans in the Commonwealth of Virginia must recognize creditable coverage so long as the employee has at least 18 months of creditable coverage and received their most recent health coverage under an employment-related group health plan. Please note that periods of creditable coverage prior to a 63-day break in coverage may be disregarded by the new health plan. You may obtain additional certificates for you or your covered family members from your Agency Benefits Administrator (or the Virginia Retirement System for retirees) should you need them during the 24 months following your termination from the plan.

Date of This Certificate: _____

Name of Participant: _____

Name of Health Care Plan: _____

Participant's Identification Number: _____

Membership Level (Single, Employee + One, Family): _____

Names of Dependents for Whom This Certificate Also Applies: _____

_____

Was the Period of Creditable Coverage More than 18 Months? (Yes/No): _____
(Disregarding periods of coverage before a 63-day break)

If Less Than 18 Months, Date Coverage Began: _____

Date Coverage
Ended: _____

Date Waiting Period Began: Not Applicable

Person preparing this certificate and to whom questions should be addressed:

Name: _____

Address: _____

_____

Agency: _____ Telephone No: _____

Note: Separate certificates will be furnished if information is not identical for the participant and each beneficiary.